STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115145	A. BUILDING ______ B. WING _____	**03/08/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDERSON MILL HEALTH AND REHABILITATION CENTER	**2130 ANDERSON MILL RD AUSTELL, GA 30106**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0323

Level of harm - Immediate jeopardy

Residents Affected - Few

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon observation, record review, staff and family interviews the facility failed to provide an environment that was free of accident hazards, including one resident (R#1), with wandering and elopement behaviors and was wearing a Wanderguard, who was found in the parking lot, by staff, the evening of 9/28/2016 then who eloped from the facility's main door, on Saturday, 10/1/2016, and fell on the main road (Anderson Mill Road) sustaining a hematoma to the back of her head. This had the likelihood to affect eleven residents (R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, and R#11) with wandering behaviors who wore Wanderguard bracelets.

The facility's Interim Administrator, Director of Regulatory Compliance, and the Interim Director of Nursing (DON) were notified of the Immediate Jeopardy on 3/6/2017 at 2:00 p.m. The non-compliance related to the Immediate Jeopardy was identified to have existed on 9/28/2016, when R#1, wearing a Wanderguard bracelet, was found by staff in the parking lot and then on 10/1/2016 eloped through the front door of the facility and fell on the main road (Anderson Mill Road) sustaining a hematoma to the back of her head. The noncompliance related to the Immediate Jeopardy continued through 3/7/2017 and was removed on 3/8/2017.

The Immediate Jeopardy is outlined as follows:

The Immediate Jeopardy was related to the facility's non-compliance with the program requirements at 42 C.F.R.:

483.25(h), Accidents/Hazards (F323 S/S: J)

483.75, Administration (F490 S/S: J)

483.75(o)(1), Quality Assessment and Assurance Committee Members/Meet Quarterly/Plans (F520 S/S: (J)

Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25(h), Accidents/Hazards (F323 S/S: J).

On 3/8/2017, the facility provided a Credible Allegation Compliance (AOC) of Jeopardy Removal alleging that interventions had been put into place to remove the immediate jeopardy on 3/8/2017. Although based on observations, record reviews and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 3/8/2017. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of residents with Wanderguards to prevent any future elopements from the facility. The oversight process included the analysis of facility staffs' conformance with the facility's Policy and Procedures governing Wanderguards and Elopement. In-service materials and records were reviewed. Observation and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's Policies and Procedure for Wanderguards and Elopement. Resident records were reviewed to ensure that resident assessments for elopement were completed, that Physician Orders were current and accurate and that care plans were updated for resident with wandering behaviors.

Findings include:

A telephone interview with the family of R#1 on 2/20/2017 at 5:02 p.m., revealed that the resident had eloped from the facility on 10/1/2016, fell on the main road (Anderson Mill Road), sustained a hematoma to the back of the resident's head and was transferred to the hospital for evaluation on the same day. The family member further revealed that the resident was wearing a Wanderguard bracelet and used a walker for ambulation at the time of the accident.

Review of the care plan for R#1 dated 3/15/2016 and revised on 2/20/2017 revealed plans for:

Elopement risk/wanderer by attempting to leave facility unattended with intervention including to distract resident from wandering offering pleasant diversions, structured activities, food, conversation, television, book. Wander Alert: Wanderguard bracelet.

Review of the resident's care plan initiated 3/15/2016 identified R#1 had a problem with wandering due to confusion. The interventions included distracting the resident from wandering and the care plan interventions did include placement checks, of the Wanderguard, every shift as ordered by physician. Additionally, the care plan revealed a focus note dated 9/28/2016 that the resident was noted in the parking lot. Returned to facility. Further review of the care plan for R#1 revealed that new interventions to prevent elopement were not put into place which is the date the Immediate Jeopardy began.

Review of the medical record for R#1 revealed that the resident was admitted into the facility 3/3/2016. Medical [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) summary score of eight (8) indicating mild cognitive impairment. Wandering behavior occurred one to three days of the look back period. Review of the functional status revealed R#1 required limited assistance for transfers, walking in her room and in corridors and on the unit and limited assistance for ambulation off the unit. Use of mobility devices include walker and wheelchair. R#1 was assessed to have no falls during the assessment period of 9/29/2016.

Interview on 3/6/2017 at 3:27 p.m. with Licensed Practical Nurse (LPN) KK, MDS Coordinator, revealed that she updated R#1 care plan on 9/29/2016 due to the elopement into the parking lot. She further revealed she received the information in the Clinical meeting, where information is shared through reading or hearing the information about a resident. She also stated on the Wednesday morning of 9/29/2016, she was unable to recall, who gave her the information, that resident was found in the parking lot of facility on 9/28/2016. She further revealed that she did not ask for any paper work about the incident or discuss with staff possible new interventions to prevent another elopement.

A review of the physician's orders dated 3/9/2016 revealed an order for [REDACTED].

Review of Medication Administration Record (MAR) for R#1 for September 2016 and October, 2016, revealed Wanderguard was checked for placement every shift.

An interview with the former Administrator on 2/20/2017 at 6:14 p.m. revealed that she was not aware of a resident with a Wanderguard leaving the facility on 10/1/2016 nor was she aware of R#1 being found in the parking lot on 9/28/2016. She looked at the resident's record, and stated that R#1 did leave from the facility on 10/1/2016 and fell in the street outside of the facility and had to be sent to the hospital. The Administrator further revealed that she is to be called, by staff, for any unusual incident within the facility and doesn't remember getting a phone call about R#1 eloping from the facility. She stated that in the morning meeting at 9 a.m. daily, the Director of Nursing (DON) will read from the 24 Hour Report and the team members will discuss the situation. She revealed that she attends the Morning Meeting but was not certain if she was in the meeting on 10/1/2016 and that she was not aware of the resident's elopement. Review of the facility 24 hour reports for the month of September 2016 revealed there was no notation of the elopement of R#1 on

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0323

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
9/28/2016.
Interview and observation of the door alarm system on 2/20/2017 at 6:30 p.m. with the former Maintenance Director (MD) EEE, revealed that she did not remember a resident eloping from the facility on 10/1/2016 or any resident eloping from the facility. She stated they use a Wanderguard activator to close the door at 7:00 p.m. nightly and open the door at 6:00 a.m. daily. She stated when you press on the door for twenty (20) seconds, the door will reopened and the alarms on the A hall are activated. Additional test by the MD EEE, and observed by the surveyor, of the main egress door indicated a chirping sound when the Wanderguard bracelet was near the door. All Wanderguards (11 residents) were checked at this time for functioning by MD EEE and all were functioning.
Interview on 2/21/2017 at 3:41 p.m., by telephone, with LPN FF revealed she was assigned to work on 200 and 400 Halls on the 11:00 p.m. to 7:00 a.m. shift beginning on 9/30/2016 through 10/1/2016 and R#1 was one her residents. She stated that on 10/1/2016 the resident was returned to her unit by Registered Nurse (RN) HH who stated that R#1 had left the building and fell in the street, outside the facility, and was brought back in the facility in a wheelchair. She stated the resident was ok except for a bump on the back of her head. She stated the resident was sent out to the hospital for examination. LPN FF further revealed that she informed the doctor, the family member and the facility Administrator. LPN FF stated it took a minute to get in touch with the Administrator and she told the Administrator what had happen to the resident, the resident elopement and a bump to the back of R#1 head. She also told the Administrator the resident was sent to the hospital. LPN FF stated the Administrator thanked her for the information and stated that RN HH had already contacted her. She stated the Wanderguard was checked and it was working and that she conducted a neurological check on R#1 although she did not document it. She also stated the incident was recorded on the 24 Hour report.
Interview on 2/21/2017 at 4:18 p.m. by telephone with RN HH revealed she was assigned to 500 and 600 Halls on 9/30/16 and at around 6:30 a.m. on 10/1/2016 a housekeeper came into Room 618 and told her a resident had fallen on the street outside of the facility. She stated she ran to the street and saw the resident on the sidewalk with her walker. She stated she assessed the resident and the CNA brought a wheelchair outside and she placed R#1 in the wheelchair and returned her to LPN FF for further assessment. RN HH stated it was a very busy night and that she sent a text to the former Administrator with information about the night shift, including the elopement and the resident's name to the Administrator. She further revealed that the Administrator responded by saying what a busy night.
Interview on 2/21/2017 at 12:40 p.m. with the Director of Nursing (DON) revealed she was not present in the facility until January 2017. She further revealed she could not locate any information about the elopement addressed by the interdisciplinary team or any investigation of how the elopement occurred on either 9/28/2016 or 10/1/2016.
A telephone interview on 2/21/2017 at 3:15 p.m. with Housekeeper EE revealed that she arrived at the facility on 10/1/2016 at approximately 6:30 a.m. when she saw a female parked half way in the driveway and half way on the street. She stated her husband continued into the facility's parking lot and parked the car. She further revealed that while walking into the facility she heard the lady say one of your resident has fallen in the middle of the street. The housekeeper entered the facility through an open door and got a nurse to help the resident. Two CNAs also helped her to bring the resident back into the facility. Housekeeper EE further revealed that the lady with the black car, at the driveway, was on her phone and called 911.
Review of the 911 report, revealed the call came in to Fire and Rescue at 6:38 a.m. on 10/1/2016 but was canceled by the police department who was on scene.
Review of Sunrise Sunset times for Austell Georgia on 10/1/2016 revealed that sunrise occurred at 7:08 a.m. and that R#1 fell in the street at approximately 6:30 a.m. on Saturday, 10/1/2016 while it was dark outside.
Interview on 2/22/2017 at 2:49 p.m. with the Facility Medical Director (FMD) revealed if the documentation stated he was informed, then he was informed. He further revealed that on 10/2/2016 he was in the building, and did not discuss elopement with anyone. The FMD stated he did not remember elopement being discussed in the QAPI meeting in October 2016, but falls were discussed including the root cause analysis.
Observation, by the surveyor, on Tuesday, 3/7/2017 at 6:40 a.m. until 7:05 a.m. revealed that it was dark, although with street lights, a flashlight was not needed. Observation of the cars along the road revealed a total of one hundred and ninety-four (194) motor vehicles were observed on Anderson Mill Road, directly in front of the facility's entrance to the parking lot. The road has a total of two (2) lanes, measuring twenty-five (25) feet across the street. The motor vehicles included cars, vans, small trucks, SUV, one (1) small school bus, and (1) regular size school bus. The speed limit was thirty-five (35) miles per hour. Anderson Mill Road connects to Highway 5 which is a major thoroughfare in the area.
Review of the Progress Notes dated 10/1/2016 at 7:00 a.m. revealed The resident was observed outside the facility by a housekeeping employee, which notified staff at A Hall station. Nursing staff from A Hall Nurse's station observed the resident laying in the road (Anderson Mill Road), and they directed traffic around this resident to avoid her being hit by a car. They then assisted her back into the facility with a wheelchair. Upon assessment, resident able to ambulate with walker, is alert with confusion, which is normal for her. She does have a hematoma on the back of her head. Neurological check done and were within normal limits (WNL) for her. Family notified on 10/1/2016 at 7:00 a.m. and the resident's physician on 10/1/2016 at 6:45 a.m. which was signed by LPN FF.
Review of the Transfer Form documents that R#1 was transferred to the hospital on [DATE].
Progress notes dated 10/1/2016 at 11:11 a.m. revealed the resident is in the emergency room .
Review of the 24 hour Report/Change of Condition Report dated 9/30/2016 (to include any condition changes within the past 24 hours) revealed that R#1 was sent to the emergency room (ER) at 7:15 a.m. Review of remarks: Elopement (Wanderguard in place) visitor let her out front door. fell in road-hit head (on 10/1/2016), sent to ER 7:15 a.m. Family notified.
Physician paged, awaiting response. The surveyor reviewed all 24 hour Report/Change of Condition reports for the month of September 2016 which did not contain a notation of finding the resident in the parking lot on 9/28/2016.
Review of the hospital Emergency records dated 10/1/2016 from 7:45 a.m. until 11:21 a.m. revealed the resident had a small hematoma to scalp. No other complaints, but considering age and relatively frailty, in addition to being on ASA (Aspirin), will get CT scan of head, C-spine x-ray, chest x-ray and pelvis x-ray and labs. Findings on the same day at 9:55 a.m. revealed that labs and imaging unremarkable. Patient feels well and patient's sister at bedside, agrees that she is at her baseline. Will arrange EMS (Emergency Medical Services) transport back to her NH (Nursing Home).
Review of the Progress Notes dated 10/1/2016 at 12:46 p.m. revealed resident returned from hospital via EMS per stretcher accompanied per family member without broken or bruised areas. No new orders. Vital signs are stable. No c/o (complaints) voiced.
Review of the Direct Supply TELS LOGBOOK DOCUMENTATION for 9/19/2016 through 9/24/2016, 9/27/2016 through 10/1/2016 and
10/3/2016 through 10/8/2016 revealed that seven doors are checked daily to determine: Door is secured, Door opens freely, Door closes smoothly, Door closes quickly, Door latches properly. Review of the Logbook revealed that the current MD FFF checks these doors daily but does not indicate if the Wanderguard system is checked.
An interview with the interim MD FFF on 3/7/2017 at 12:32 p.m. revealed that the company responsible for maintaining the Wanderguard system and the door locks was in the building on 2/22/2017 and found there was a cross up between the Wanderguard and the key pad on the main entrance door. He further revealed that the cross up, if someone entered the code into the key pad, would disable the Wanderguard system. The company separated the key pad and the Wanderguard system to ensure that, if someone used the key pad, it would not disable the Wanderguard system. The doors automatically lock between 8:00 p.m. and 8:10 p.m. and reopen automatically between 6:00 a.m. and 6:10 a.m. which MD FFF has checked and are working properly.
Review of the Progress Notes dated 10/4/2016 at 11:50 p.m. revealed the resident was complaining of chest pain mid-sternum and transferred to the emergency room . The resident returned from the hospital on the same day at 11:50 a.m. without new orders.
Review of the Progress Notes dated 10/9/2016 at 12:35 p.m. revealed the resident has increased confusion, denies pain or discomfort when voiding. Resident has tried to elope and is more confused. The hospital physician called and ordered Macrobid (antibiotic) for seven days for a Urinary Tract Infection (UTI).
Record review of the facility policy titled Resident Elopement Revised August 2012 revealed:
Policy: The facility strives to provide a safe environment and preventive measures for elopement. Personnel must report and investigate all reports of missing residents.
Fundamental Information: It is the responsibility of all personnel to report any resident attempting to leave the premises,

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F 0323

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 2)
or suspected of being missing, to the DON and the Administrator and to document the occurrence.
Procedure: Prevention, 1. Facility creates a photographic directory of residents identified at risk for elopement. a. Photograph residents identified at risk for elopement by the Nursing Admission Assessment upon admission. b. Store printed photographs, labeled with resident name and room number, in a binder. Multiple binders may be created if facility has multiple egress locations.
Wander/Elopement Alarm Activation: 1. If an employee hears a door alarm, he or she should: a. Immediately go to the site of the alarm. b. If a resident is observed attempting to elope, follow the steps outlined below for Attempted Elopement. c. If no resident is found to be exiting the facility, the employee should i. Exit the facility, walk around the building, and ensure that a resident has not already exited the facility; ii. Notify the Director of Nursing and the Administrator immediately; and iii. Complete a head count to ensure all residents are accounted for.
Attempted Elopement, 1. If an employee observes an attempted elopement, he or she should: a. Be courteous in preventing the departure and in returning the resident to the facility. b. Obtain assistance from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the DON and the Administrator that a resident is attempting to leave the premises. 2. Upon return of the resident to the facility, the Director of Nursing and the Administrator should: a. Examine the resident for injuries (DON), b. Contract the attending physician, report what happened, and follow the physician's orders; c. Contact the resident's legal representative and inform them of the incident; d. Complete and file an Incident/Accident Report, (Briggs), e. Make appropriate notations in the resident's medical record (DON), f. Investigate how the resident attempted to elope and make recommendations regarding safety measures to the Quality Assurance and Performance Improvement Committee; and g. Update the resident's care plan with preventive interventions for elopement (DON).
Observation of R#1 on 2/27/2017 at 11:59 a.m. revealed the resident was sitting in her wheelchair, watching television, very pleasant when approached and stated everything was ok. The resident's Wanderguard bracelet was in place.
The facility could not produce evidence that the elopement of R#1 had been investigated prior to 2/20/2017, for either the 9/28/2016 or 10/1/2016 elopement, nor to determine the cause of the elopement or interventions to prevent the elopement of R#1 or the 10 residents with Wanderguard bracelets.
The facility implemented the following actions to remove the Immediate Jeopardy:
1. On 2/20/2017 a review of the facility Resident Elopement policy was completed by the Facility administration team. An addendum was created, Elopement Response which includes instituting a staff alert/announcement procedure identifying a missing resident as a Code Yellow, location for staff to report to initiate a comprehensive search, notification of the family, physician, facility Administrator, Facility Director of Nursing and the police when necessary.
2. On 2/20/2017 the facility Unit Managers completed a chart review and all residents that are identified at risk for elopement and had Wanderguard in place. 11 residents were reviewed and 1 resident's Wanderguard was discontinued. As of March 8, 2017 there are 11 residents remain with Wanderguards at this time. These Wanderguards will be checked for placement by the licensed nurse and documented on the Medication Administration Record every shift. These Wandergards are being checked for proper function by a Licensed Nurse and documented on the Medication Administration Record every day. New Admission residents are assessed upon admission for Elopement Risk using the Nursing Data Collection Form. If a resident is found to be at risk a physician order for [REDACTED]. The Wanderguard placement will be checked by the licensed nurse and documented on the Medication Administration Record. The Wanderguard function will be checked by the licensed nurse daily and documented on the Medication Administration Record.
3. On 2/20/2017 the facility Unit Managers completed a new Elopement Assessment on all residents documenting this assessment in the Elopement Assessment form located in Point Click Care.
4. On 2/20/2017 the facility Unit Managers reviewed and updated the care plans for residents at risk for elopement.
5. On 2/20/2017 the interdisciplinary team reviewed and updated the Elopement Risk Binders located at each Nurses station and the front desk.
6. On 2/20/2017 the facility Unit Managers reviewed and updated physician orders for check for placement and functioning of the Wanderguard for every shift. This occurred for 11 residents.
7. On 2/20/2017 the Wanderguard system for the front door of the facility was upgraded, allowing it to remain active even when in Night mode. A new keypad was added for the inside of the building to operate the doors at night, and separated the Wanderguard system from the timer. This allowed the Wanderguard system to remain active and capable of locking the doors 24/7.
8. On 2/20/2017 the District Director of Clinical Services checked the front lobby Wanderguard system and it was functioning properly.
9. On 2/24/2017 the Maintenance Director checked all Wanderguards for functioning and all were functioning properly. Maintenance Director completes checks of Wandergard door system every day and documenting these checks on Weekly Checklist for Door Modules.
10. On 3/6/2017 the Contract Company installed 4 annunciators throughout the facility and installed 1 additional Annunciator panel for staff to be able to quickly tell what door has been breached.
11. On 2/20/2017 at 8:00 p.m. continuous front lobby door monitoring started. An employee was assigned to the front lobby door to observe entrance/exit of staff/visitors/vendors/residents. These observations are documented every hour on the Door Monitoring form. Documentation includes if the door alarms, if the door alarmed, why and what action was taken.
12. On 2/23/2017 the Administrator was placed on Administrative leave and is no longer employed at Anderson Mill as of 3/7/2017.
13. On 3/7/2017 signage was added to the doorways alerting visitors to please do not assist any of our residents outside without checking with the nursing staff.
14. On 2/20/2017 the managers began to educate staff on the Elopement policy. As of 3/7/2017, (89.6%) 138 out of 154 employees which includes the contracted staff were educated and 1 RCS, 1 RN supervisor, 1 Maintenance on LOA. The following employees received the education; 2 Activity employees, 2 Admissions Coordinators, 2 Business office, 1 medical records, 17 LPNs, 2 Maintenance department, 4 MDS, 15 Occupational therapists, 2 front office, 1 receptionist, 30 RCS, 1 Respiratory therapist, 2 Restorative RCS, 1 RN, 2 Social Services, 1 SDC, 1 RN unit manager, 3 LPN unit managers, 1 LPN wound care, 11 Dietary, and 12
Housekeeping/Laundry, 5 Speech Therapists, 1 Rehab aide, 14 physical therapists, 1 DON (interim contracted DON) and 4 agency nurses. Any staff that has not received this education will not be permitted to work until education is completed. Newly hired employees and any new agency staff will receive this education prior to working. The interim Administrator has been educated by the Director of Nursing related to the Elopement policy.
15. On 2/24/2017 the facility department managers began questioning 1 employee per day while in the facility on:
What type of events would you report to the Administrator of DON?
What would you do if the Administrator or DON did not respond to your call? What would you do if you felt your reported issue was not taken seriously?
What would you do if you felt that your supervisor or another manager was not being truthful about events occuring in the facility?
Are you aware of any events that have occured that may not have been reported? Do you know where the corporate compliance hotline is?
What is code Yellow?
What would you do if the Wanderguard system, was alarming, but when you went to the front lobby there was no resident in the area?
The Staff Survey Questions monitoring forms were completed with 34 employees from 3/2/24- 3/5/17, 20 employees on3/6/2017, 19 employees on 3/7/2017 and documented on Staff Survey Question monitoring forms.
16. An Adhoc QAPI meeting was held on 3/6/2017 at 12:30pm. Medical Director attended by conference call and the following employees were present; interim Administrator, A/R coordinator, interim DON, Medical Records Coordinator, LPN DD, Unit Manager, Registered Nurse HHH, MDS Manager, Social Services (SS) Director QQ, SS assistant III, Admission Coordinator, Interim Rehab Program Manager, Business Office Director, Activity Director, interim Maintenance Director and the Director of Regulatory Compliance. Agenda items related to both complaint surveys.
17. On 2/20/2017 the facility implemented a procedure by which the results of the monitoring referenced above, to be

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Level of harm - Immediate jeopardy

Residents Affected - Few

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documented on the audit monitoring and completed tools form, would be presented to the Quality Assurance Committee each month by the Administrator and/or the DON, to allow the QA committee to monitor staff compliance with the facility's policies and procedures regarding Resident Elopement and Elopement Response.
The State Survey Agency validated on 3/8/2017 the corrective action taken by the facility as follows:
1. Review of the addendum to the Elopement Policy titled Elopement Response dated 2/20/2017 signed by the interim Administrator. Notification by using Code Yellow for missing resident was implemented then to follow the current policy for notification.
2. Review on 3/8/2017 of the facility Wanderguard list revealed eleven (11) residents on the list. Review of the Medication Administration Record (MAR) for R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10 and R#11, revealed that the documentation of the Wanderguards are on the MARs with note to check for placement and functioning, a Physician's order for the Wanderguard was noted for each resident. Review of the Elopement Books revealed that all eleven resident's had their photographs and information entered into the Elopement Books kept at the Nurse's Station. There were no new admissions to check at this time.
3. Review of Point Click Care for the eleven residents with wandering behaviors the surveyor confirmed that all eleven residents were assessed for Elopement risk on 2/20/2017. Two residents, R#8 and R#10, were assessed with [REDACTED]. Review of the Elopement Assessment, dated 2/20/2017, for R#17, R#18, R#19, R#20, R#21, R#22, R#23, R#24, R#25, R#26, R#27, R#28, R#29, R#30, R#31 and R#32 revealed the residents were not at risk nor had behaviors that would warrant the use of a Wanderguard.
4. Review of the Care Plans for R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10 and R#11 revealed an update dated 2/20/2017 that the residents are an elopement risk/wander. Resident wanders aimlessly, impaired safety awareness. Interventions: Check placement and function of safety monitoring device every shift, Observe location at regular and frequent intervals. Document wandering behavior and attempted diversional interventions. The care plans were additionally personalized for each resident.
5. Review of the Elopement Risk Binders located at each Nurse's Station and the Front desk revealed the binder's had been updated to include the 11 resident's currently at risk for elopement.
6. Review of the Physician's Orders revealed the orders were updated for check for placement and functioning of Wanderguard for every shift for the eleven residents with Wanderguards.
7. Review of the Contractor invoice dated 2/22/2017 that the Wanderguard has been separated from the Key Pad and locks to work independently. Further review reveals the Contractor also educated staff on the Egress Locks.
Observation on 3/8/2017 at 3:00 p.m. with the Maintenance Director revealed the new keypad and the separation of the Wanderguard from the timer and the Wanderguard system is working properly.
8. Review on 3/8/2017 of the checklist titled Wanderguard System Check dated 2/20/2017 through 2/23/2017 was completed by the Director of Clinical Services three times each day.
9. Review on 3/8/2017 revealed that the interim MD was checking the Wanderguard system daily and was noted on the daily door checklist.
10. Review of the Contractor invoice dated 3/6/2017 revealed that one secondary Wanderguard annunciator had been installed on the rear Nurse's Station (B Hall) which will allow staff to see which door had been breached. Additionally, four alarms had been added throughout the facility to alarm staff of a Wanderguard breach. This was confirmed by Observation, by the surveyor, on 3/8/2017 at 3:00 p.m. with the interim MD.
11. Review of the hourly monitoring of the front door sign off sheets revealed that staff had been assigned to the door and noted hourly beginning 2/20/2017 at 8:00 p.m. and continued through 3/7/2017 at 9:00 a.m.
12. Notification via e-mail was received by the State Survey Agency on 2/28/2017 at 12:48 p.m. from the facility's corporate office that the Administrator had been placed on administrative leave as of 2/23/2017, pending investigation of R#1's elopement on 10/1/2017 . Review of the Separation Noticed dated 3/8/2017 revealed that the Administrator (referred to as previous) had been terminated from employment as of 3/7/2017.
13. Observation on 3/8/2017 at 3:15 p.m. revealed the signage at the doorways stating Attention Visitors and Family Members: For the safety of our resident's please do not assist other residents outside of the facility without staff approval.
14. Review of the in-service sign-in sheets revealed that in-services were held on 2/20/2017 with 68 staff in-serviced, 2/22/2017 with 52 staff in-serviced, on 2/23/2017 with six staff members in-serviced and one staff member was in-serviced on 2/24/2017 and 10 employees in-serviced on 3/7/2017 for a total of 137 staff members (direct employees and contract employees) of

F 0490

Level of harm - Immediate jeopardy

Residents Affected - Few

Be administered in an acceptable way that maintains the well-being of each resident .
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on family and staff interviews, record review and review of the facility's Policy and Procedure for Elopement, it was determined the facility failed to be administered in a manner to investigate an Elopement of one resident (R#1) as to the cause and to prevent the likelyhood of elopement for the additional ten (10) at risk residents (R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, and R#11) of a total of eleven residents with wandering behaviors and wearing a Wanderguard bracelet.
The facility's Interim Administrator, Director of Regulatory Compliance, and the Interim Director of Nursing (DON) were notified of the Immediate Jeopardy on 3/6/2017 at 2:00 p.m. The non-compliance related to the Immediate Jeopardy was identified to have existed on 9/28/2016, the date a resident (R#1) wearing a Wanderguard, was found in the parking lot by staff on the 3:00 p.m. to 11:00 p.m. shift followed on 10/1/2017 when the resident eloped through the front door of the facility and fell on the main road (Anderson Mill Road) sustaining a hematoma to the back of her head. The noncompliance related to the Immediate Jeopardy continued through 3/7/2017 and was removed on 3/8/2017.
The Immediate Jeopardy is outlined as follows:
The Immediate Jeopardy was related to the facility's non-compliance with the program requirements at 42 C.F.R.:
483.25(h), Accidents/Hazards (F323 S/S: J)
483.75, Administration (F490 S/S: J)
483.75(o)(1), Quality Assessment and Assurance Committee Members/Meet Quarterly/Plans
(F520 S/S: (J)
Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25(h), Accidents/Hazards (F323 S/S: J).
On 3/8/2017, the facility provided a Credible Allegation Compliance (AOC) of Jeopardy Removal alleging that interventions had been put into place to remove the immediate jeopardy on 3/8/2017. Based on observations, record reviews and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 3/8/2017. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of residents with Wanderguards to prevent any future elopements from the facility. The oversight process included the analysis of facility staffs' conformance with the facility's Policy and Procedures governing Wanderguards and Elopement. In-service materials and records were reviewed. Observation and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's Policies and Procedure for Wanderguards and Elopement. Resident records were reviewed to ensure that resident assessments for elopement were completed, that Physician Orders were current and accurate and that care plans were updated for resident with wandering behaviors.
Findings include:
During a telephone interview with a family member of R#1 on 2/20/2017 at 5:00 p.m., the family member revealed that R#1 had eloped from the facility on 10/1/2016 and had fallen in the main road (Anderson Mill Road). R#1 had sustained a hematoma to the back of the resident's head and was transported to the emergency room for evaluation. The family member confirmed that R#1 was wearing a Wanderguard bracelet at the time of the elopement on 10/1/2016 and used a walker for ambulation.
Review of the resident's care plan dated 3/15/2017 and revised on 2/20/2017 revealed the resident was care planned for wandering behaviors, confusion and for the use of a Wanderguard bracelet due to exit seeking behaviors. Additionally, the care plan revealed a focus note dated 9/28/2016 that the resident was noted in the parking lot. Returned to facility.
Further review of the care plan for R#1 revealed that new interventions to prevent elopement were not put into place which is the date the Immediate Jeopardy began.
An interview with the former Administrator on 2/20/2017 at 6:14 p.m. revealed that she was not aware of a resident with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115145**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/08/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDERSON MILL HEALTH AND REHABILITATION CENTER	**2130 ANDERSON MILL RD** **AUSTELL, GA 30106**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0490

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 4)
Wanderguard leaving the facility on 10/1/2016 nor was she aware of R#1 being found in the parking lot on 9/28/2016. She looked at the resident's record, and stated that R#1 did leave from the facility on 10/1/2016 and fell in the street outside of the facility and had to be sent to the hospital. The Administrator further revealed that she is to be called, by staff, for any unusual incident within the facility and doesn't remember getting a phone call about R#1 eloping from the facility. The Administrator revealed that the facility has a morning meeting daily at 9:00 a.m. which she attends although she was not certain if she had attended the meeting on 10/1/2016 and that she was not aware of the resident's elopement.
Review of the facility 24 hour reports for September 2016 revealed there was no notation of the elopement of R#1 on 9/28/2016.
Interview and observation of the door alarm system on 2/20/2017 at 6:30 p.m. with the former Maintenance Director (MD) EEE, revealed that she did not remember a resident eloping from the facility on 10/1/2016 or any resident eloping from the facility. Test by the MD EEE, and observed by the surveyor, of the main egress door indicated a chirping sound when the Wanderguard bracelet was near the door. All Wanderguards (11 residents) were checked at this time for functioning by MD EEE and all were functioning.
Interview on 2/21/2017 at 3:41 p.m., by telephone, with Licensed Practical Nurse (LPN) FF revealed she was assigned to work on 200 and 400 Halls on the 11:00 p.m. to 7:00 a.m. shift on 9/30/2016 and R#1 was one her residents. She stated the resident was returned to her unit by Registered Nurse (RN) HH who stated that R#1had left the building and fell in the street, outside the facility, and was brought back in the facility in a wheelchair. She stated the resident was ok except for a bump on the back of her head. She stated the resident was sent out to the hospital for examination. LPN FF further revealed that she informed the doctor, the family member and the facility Administrator. LPN FF stated it took a minute to get in touch with the Administrator and she told the Administrator what had happen to the resident, the resident elopement and a bump to the back of R#1 head. She also told the Administrator the resident was sent to the hospital. LPN FF stated the Administrator thanked her for the information and stated that RN HH had already contacted her. She stated the Wanderguard was checked and it was working and that she conducted a neurological check on R#1 although she did not document it. She also stated the incident was recorded on the 24 Hour report.
Interview on 2/21/2017 at 4:18 p.m. by telephone with Registered Nurse (RN) HH revealed she was assigned to 500 and 600 Halls on 9/30/16 and at around 6:30 a.m. on 10/1/2016 a housekeeper came into room [ROOM NUMBER] and told her a resident had fallen on the street outside of the facility. She stated she ran to the street and saw the resident on the sidewalk with her walker. She stated she assessed the resident and the Certified Nursing Assistant (CNA) brought a wheelchair outside and she placed R#1 in the wheelchair and returned her to LPN FF for further assessment. RN HH stated it was a very busy night and that she sent a text to the former Administrator with information about the night shift, including the elopement and the resident's name to the Administrator. She further revealed that the Administrator responded by saying what a busy night.
Record review of the facility policy titled Resident Elopement Revised August 2012 revealed:
Policy: The facility strives to provide a safe environment and preventive measures for elopement. Personnel must report and investigate all reports of missing residents.
Fundamental Information: It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the DON and the Administrator and to document the occurrence.
Procedure: Prevention, 1. Facility creates a photographic directory of residents identified at risk for elopement. a. Photograph residents identified at risk for elopement by the Nursing Admission Assessment upon admission. b. Store printed photographs, labeled with resident name and room number, in a binder. Multiple binders may be created if facility has multiple egress locations.
Wander/Elopement Alarm Activation: 1. If an employee hears a door alarm, he or she should: a. Immediately go to the site of the alarm. b. If a resident is observed attempting to elope, follow the steps outlined below for Attempted Elopement. c. If no resident is found to be exiting the facility, the employee should i. Exit the facility, walk around the building, and ensure that a resident has not already exited the facility; ii. Notify the Director of Nursing and the Administrator immediately; and iii. Complete a head count to ensure all residents are accounted for.
Attempted Elopement, 1. If an employee observes an attempted elopement, he or she should: a. Be courteous in preventing the departure and in returning the resident to the facility. b. Obtain assistance from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the DON and the Administrator that a resident is attempting to leave the premises. 2. Upon return of the resident to the facility, the Director of Nursing and the Administrator should: a. Examine the resident for injuries (DON), b. Contract the attending physician, report what happened, and follow the physician's orders; c. Contact the resident's legal representative and inform them of the incident; d. Complete and file an Incident/Accident Report, (Briggs), e. Make appropriate notations in the resident's medical record (DON), f. Investigate how the resident attempted to elope and make recommendations regarding safety measures to the Quality Assurance and Performance Improvement Committee; and g. Update the resident's care plan with preventive interventions for elopement (DON).
The facility could not produce evidence that the elopement of R#1 had been investigated prior to 2/20/2017, for either the 9/28/2016 or 10/1/2016 elopement, nor to determine the cause of the elopement or interventions to prevent the elopement of R#1 or the 10 residents with Wanderguard bracelets.
Cross refer to F323
The facility implemented the following actions to remove the Immediate Jeopardy:
1. On 2/20/2017 a review of the facility Resident Elopement policy was completed by the Facility administration team. An addendum was created, Elopement Response which includes instituting a staff alert/announcement procedure identifying a missing resident as a Code Yellow, location for staff to report to initiate a comprehensive search, notification of the family, physician, facility Administrator, Facility Director of Nursing and the police when necessary.
2. On 2/22/2017 the Wanderguard system for the front door of the facility was upgraded, allowing it to remain active even when in Night mode. A new keypad was added for the inside of the building to operate the doors at night, and separated the Wanderguard system from the timer. This allowed the Wanderguard system to remain active and capable of locking the doors 24/7.
3. On 2/20/2017 at 8:00 p.m. continuous front lobby door monitoring started. An employee was assigned to the front lobby door to observe entrance/exit of staff/visitors/vendors/residents. These observations are documented every hour on the Door Monitoring form. Documentation includes if the door alarms and if the door alarmed, why and what action was taken.
4. On 2/23/2017 the Administrator was placed on Administrative leave and is no longer employed at(NAME)Mill as of 3/7/2017.
The State Survey Agency validated on 3/8/2017 the corrective action taken by the facility as follows:
1. Review of the addendum to the Elopement Policy titled Elopement Response dated 2/20/2017 signed by the interim Administrator. Notification by using Code Yellow for missing resident was implemented then to follow the current policy for notification.
2. Review of the Contractor invoice dated 2/22/2017 that the Wanderguard has been separated from the Key Pad and locks to work independently. Further review reveals the Contractor also educated staff on the Egress Locks.
Observation on 3/8/2017 at 3:00 p.m. with the Maintenance Director revealed the new keypad and the separation of the Wanderguard from the timer and the Wanderguard system is working properly.
3. Review of the hourly monitoring of the front door sign off sheets revealed that staff had been assigned to the door and noted hourly beginning 2/20/2017 at 8:00 p.m. and continued through 3/7/2017 at 9:00 a.m.
4. Notification via e-mail was received by the State Survey Agency on 2/28/2017 at 12:48 p.m. from the facility's corporate office that the Administrator had been placed on administrative leave as of 2/23/2017, pending investigation of the 10/1/2016 Elopement of R#1. Review of the Separation Noticed dated 3/8/2017 revealed that the Administrator (referred to as previous) had been terminated from employment as of 3/7/2017.

F 0520

Level of harm - Immediate jeopardy

Residents Affected - Few

Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115145**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/08/2017**

NAME OF PROVIDER OF SUPPLIER **ANDERSON MILL HEALTH AND REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **2130 ANDERSON MILL RD AUSTELL, GA 30106**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0520

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 5)
Based on observation, record review and staff interview, it was determined that the facility failed to maintain a Quality Assurance Performance Improvement (QAPI) committee that identified, developed and implemented corrective action plans to correct a problem of the Wanderguard System not functioning properly to prevent the Elopement of one resident (R#1) and to ensure that ten (R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, and R#11) additional residents with wandering behavior, who were wearing Wanderguards bracelets did not exit the facility unattended.
The facility's Interim Administrator, Director of Regulatory Compliance, and the Interim Director of Nursing (DON) were notified of the Immediate Jeopardy on 3/6/2017 at 2:00 p.m. The non-compliance related to the Immediate Jeopardy was identified to have existed on 9/28/2016, when R#1, wearing a Wanderguard bracelet, was found by staff in the parking lot and then on 10/1/2016 eloped through the front door of the facility and fell on the main road (Anderson Mill Road) sustaining a hematoma to the back of her head. The noncompliance related to the Immediate Jeopardy continued through 3/7/2017 and was removed on 3/8/2017.
The Immediate Jeopardy is outlined as follows:
The Immediate Jeopardy was related to the facility's non-compliance with the program requirements at 42 C.F.R.:
483.25(h), Accidents/Hazards (F323 S/S: J)
483.75, Administration (F490 S/S: J)
483.75(o)(1), Quality Assessment and Assurance Committee Members/Meet Quarterly/Plans
(F520 S/S: (J)
Additionally, Substandard Quality of Care was identified with the requirements at 42 C.F.R. 483.25(h), Accidents/Hazards (F323 S/S: J).
On 3/8/2017, the facility provided a Credible Allegation Compliance (AOC) of Jeopardy Removal alleging that interventions had been put into place to remove the immediate jeopardy on 3/8/2017. Based on observations, record reviews and review of the facility's policies as outlined in the Credible Allegation of Compliance, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 3/8/2017. The facility remained out of compliance at a lower scope and severity of D while the facility continued management level staff oversight of residents with Wanderguards to prevent any future elopements from the facility. The oversight process included the analysis of facility staffs' conformance with the facility's Policy and Procedures governing Wanderguards and Elopement. In-service materials and records were reviewed. Observation and interviews were conducted with staff to ensure they demonstrated knowledge of the facility's Policies and Procedure for Wanderguards and Elopement. Resident records were reviewed to ensure that resident assessments for elopement were completed, that Physician order [REDACTED].
Findings include:
An interview on 3/8/2017 at 6:22 p.m., with the interim Administrator, revealed that the QAPI meets monthly. The interim Administrator revealed that the QAPI meetings were held on 10/19/2016 and 12/21/2016 although there was no evidence that Elopement was discussed in these meetings. The interim Administrator did produce sign-in sheets from the Adhoc QAPI meeting held on 3/6/2017 where the Immediate Jeopardy related to Elopement and Wanderguards was discussed, the Allegation of Credible Compliance (AOC) was addressed and the Action Plan, to prevent further elopement which the facility began immediately on 2/20/2017 when the problem with the main entrance was brought to the facility's attention.

An interview with the Medical Director on 2/22/2017 at 2:49 p.m. revealed that he attended the October 2016 QAPI meeting but does not remember discuss anything related to elopements. He further revealed he does remember that falls were discuss during that meeting.
Review of the QAPI meeting sign-in sheets revealed that on 10/19/2016 the QAPI committee met with the Administrator and the Medical Director were in attendance. Review of the QAPI sign-in sheet for 12/21/2016 revealed that the Administrator and the Medical Director were in attendance. Review of the QAPI sign-in sheet for 3/6/2017 revealed the interim Administrator, the interim Director of Nursing (DON), and the Medical Director, via conference call, plus representatives of multiple departments of the facility.
An interview with the interim Administrator on 3/8/2017 at 7:30 p.m. revealed that the facility could not produce evidence that the Elopement of R#1 on 9/28/2016 and on 10/1/2016 was addressed by the QAPI committee until 3/6/2017.
Cross refer to F323
The facility implemented the following actions to remove the Immediate Jeopardy:
1. On 2/20/2017 a review of the facility Resident Elopement policy was completed by the Facility administration team. An addendum was created, Elopement Response which includes instituting a staff alert/announcement procedure identifying a missing resident as a Code Yellow, location for staff to report to initiate a comprehensive search, notification of the family, physician, facility Administrator, Facility Director of Nursing and the police when necessary.
2. On 2/20/2017 the facility Unit Managers completed a chart review and all residents that are identified at risk for elopement and had Wanderguard in place. 11 residents were reviewed and 1 resident's Wanderguard was discontinued. As of 3/8/2017 there are 11 residents remaining with Wanderguards at this time. These Wanderguards will be checked for placement by the licensed nurse and documented on the Medication Administration Record every shift. These Wandergards are being checked for proper function by a Licensed Nurse and documented on the Medication Administration Record every day. New Admission residents are assessed upon admission for Elopement Risk using the Nursing Data Collection Form. If a resident is found to be at risk a physician order [REDACTED]. The Wanderguard placement will be checked by the licensed nurse and documented on the Medication Administration Record. The Wanderguard function will be checked by the licensed nurse daily and documented on the Medication Administration Record.
3. On 2/20/2017 the facility Unit Managers completed a new Elopement Assessment on all residents documenting this assessment in the Elopement Assessment form located in Point Click Care.
4. On 2/20/2017 the facility Unit Managers reviewed and updated the care plans for residents at risk for elopement.
5. On 2/20/2017 the interdisciplinary team reviewed and updated the Elopement Risk Binders located at each Nurses station and the front desk.
6. On 2/20/2017 the facility Unit Managers reviewed and updated physician orders [REDACTED]. This occurred for 11 residents.
7. On 2/22/2017 the Wanderguard system for the front door of the facility was upgraded, allowing it to remain active even when in Night mode. A new keypad was added for the inside of the building to operate the doors at night, and separated the Wanderguard system from the timer. This allowed the Wanderguard system to remain active and capable of locking the doors 24/7.
8. On 2/20/2017 the District Director of Clinical Services checked the front lobby Wanderguard system and it was functioning properly.
9. On 2/24/2017 the Maintenance Director checked all Wanderguards for functioning and all were functioning properly. Maintenance Director completes checks of Wandergard door system every day and documenting these checks on Weekly Checklist for Door Modules.
10. On March 6, 2017 the contractor installed 4 annunciators throughout the facility and installed 1 additional Annunciator panel for staff to be able to quickly tell what door has been breached.
11. On 2/20/2017 at 8 p.m. continuous front lobby door monitoring started. An employee was assigned to the front lobby door to observe entrance/exit of staff/visitors/vendors/residents. These observations are documented every hour on the Door Monitoring form. Documentation includes if the door alarms, if the door alarmed, why and what action was taken.
12. On 2/23/2017 the Administrator was placed on Administrative leave and is no longer employed at Anderson Mill as of March 7, 2017.
13. On 3/7/2017 signage was added to the doorways alerting visitors to please do not assist any of our residents outside without checking with the nursing staff.
14. On 2/20/2017 the managers began to educate staff on the Elopement policy. As of 3/7/2017 , (89.6%) 138 out of 154 employees which includes the contracted staff were educated and 1 RCS, 1 RN supervisor, 1 Maintenance on LOA. The following employees received the education; 2 Activity employees, 2 Admissions Coordinators, 2 Business office, 1 medical records, 17 LPNs, 2 Maintenance department, 4 MDS, 15 Occupational therapists, 2 front office, 1 receptionist, 30 RCS, 1 Respiratory therapist, 2 Restorative RCS, 1 RN, 2 Social Services, 1 SDC, 1 RN unit manager, 3 LPN unit managers, 1 LPN wound care, 11 Dietary, and 12 Housekeeping/Laundry, 5 Speech Therapists, 1 Rehab aide, 14 physical therapists, 1 DON (interim contracted DON) and 4 agency nurses. Any staff that has not received this education will not be permitted to work until education is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115145**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/08/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDERSON MILL HEALTH AND REHABILITATION CENTER	**2130 ANDERSON MILL RD AUSTELL, GA 30106**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) completed. Newly hired employees and any new agency staff will receive this education prior to working. The interim Administrator has been educated by the Director of Nursing related to the Elopement policy. 15. On 2/20/2017 the facility department managers began questioning 1 employee per day while in the facility on: What type of events would you report to the Administrator of DON? What would you do if the Administrator or DON did not respond to your call? What would you do if you felt your reported issue was not taken seriously? What would you do if you felt that your supervisor or another manager was not being truthful about events occuring in the facility? Are you aware of any events that have occured that may not have been reported? Do you know where the corporate compliance hotline is? What is code Yellow? What would you do if the Wanderguard system, was alarming, but when you went to the front lobby there was no resident in the area? The Staff Survey Questions monitoring forms were completed with 34 employees from 2/24/2017 through 3/5/17, 20 employees on 3/6/2017, 19 employees on March 7, 2017 and documented on Staff Survey Question monitoring forms. 16. An Adhoc QAPI meeting was held on 3/6/2017 at 12:30pm. Medical Director attended by conference call and the following employees were present; interim Administrator, A/R coordinator, interim DON, Medical Records Coordinator, LPN DD, Unit Manager, Registered Nurse HHH, MDS Manager, Social Services (SS) Director QQ, SS assistant III, Admission Coordinator, Interim Rehab Program Manager, Business Office Director, Activity Director, interim Maintenance Director and the Director of Regulatory Compliance. Agenda items related to both complaint surveys. 17. On 2/20/2017 the facility implemented a procedure by which the results of the monitoring referenced above, to be documented on the audit monitoring and completed tools form, would be presented to the Quality Assurance Committee each month by the Administrator and/or the DON, to allow the QA committee to monitor staff compliance with the facility's policies and procedures regarding Resident Elopement and Elopement Response. The State Survey Agency validated on 3/8/2017 the corrective action taken by the facility as follows: 1. Review of the addendum to the Elopement Policy titled Elopement Response dated 2/20/2017 signed by the interim Administrator. Notification by using Code Yellow for missing resident was implemented then to follow the current policy for notification. 2. Review on 3/8/2017 of the facility Wanderguard list revealed eleven (11) residents on the list. Review of the Medication Administration Record (MAR) for R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10 and R#11, revealed that the documentation of the Wanderguards are on the MARs with note to check for placement and functioning, a physician's orders [REDACTED]. Review of the Elopement Books revealed that all eleven resident's had their photographs and information entered into the Elopement Books kept at the Nurse's Station. There were no new admissions to check at this time. 3. Review of Point Click Care for the eleven residents with wandering behaviors the surveyor confirmed that all eleven residents were assessed for Elopement risk on 2/20/2017. Two residents, R#8 and R#10, were assessed with [REDACTED]. Review of the Elopement Assessment, dated 2/20/2017, for R#17, R#18, R#19, R#20, R#21, R#22, R#23, R#24, R#25, R#26, R#27, R#28, R#29, R#30, R#31 and R#32 revealed the residents were not at risk nor had behaviors that would warrant the use of a Wanderguard. 4. Review of the Care Plans for R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10 and R#11 revealed an update dated 2/20/2017 that the residents are an elopement risk/wander. Resident wanders aimlessly, impaired safety awareness. Interventions: Check placement and function of safety monitoring device every shift, Observe location at regular and frequent intervals. Document wandering behavior and attempted diversional interventions. The care plans were additionally personalized for each resident. 5. Review of the Elopement Risk Binders located at each Nurse's Station and the Front desk revealed the binder's had been updated to include the 11 resident's currently at risk for elopement. 6. Review of the physician's orders [REDACTED]. 7. Review of the Contractor invoice dated 2/22/2017 that the Wanderguard has been separated from the Key Pad and locks to work independently. Further review reveals the Contractor also educated staff on the Egress Locks. Observation on 3/8/2017 at 3:00 p.m. with the Maintenance Director revealed the new keypad and the separation of the Wanderguard from the timer and the Wanderguard system is working properly. 8.8. Review on 3/8/2017 of the checklist titled Wanderguard System Check dated 2/20/2017 through 2/23/2017 was completed by the Director of Clinical Services three times each day. 9. Review on 3/8/2017 revealed that the interim MD was checking the Wanderguard system daily and was noted on the daily door checklist. 10. Review of the Contractor invoice dated 3/6/2017 revealed that one secondary Wanderguard annunciator had been installed on the rear Nurse's Station (B Hall) which will allow staff to see which door had been breached. Additionally, four alarms had been added throughout the facility to alarm staff of a Wanderguard breach. This was confirmed by Observation, by the surveyor, on 3/8/2017 at 3:00 p.m. with the interim MD. 11. Review of the hourly monitoring of the front door sign off sheets revealed that staff had been assigned to the door and noted hourly beginning 2/20/2017 at 8:00 p.m. and continued through 3/7/2017 at 9:00 a.m. 12. Notification via e-mail was received by the State Survey Agency on 2/28/2017 at 12:48 p.m. from the facility's corporate office that the Administrator had been placed on administrative leave as of 2/23/2017. Review of the Separation Noticed dated 3/8/2017 revealed that the Administrator (referred to as previous) had been terminated from employment as of 3/7/2017. 13. Observation on 3/8/2017 at 3:15 p.m. revealed the signage at the doorways stating Attention Visitors and Family Members: For the safety of our resident's please do not assist other residents outside of the facility without staff approval. 14. Review of the in-service sign-in sheets revealed that in-services were held on 2/20/2017 with 68 staff in-serviced, 2/22/2017 with 52 staff in-serviced, on 2/23/2017 with six staff members in-serviced and one staff member was in-serviced on 2/24/2017 and 10 employees in-serviced on 3/7/2017 for a total of 137 staff members (direct employees and contract employees) of 154 employees related to the updated Elopement Policy and Procedures and the Reporting Process for direct care and indirect staff. In-services continued, including re-in-service of staff on 3/6/2017 with 12 staff receiving in-service, 3/7/2017 with two staff in-serviced and 3/8/2017 for both direct and indirect resident care staff. An interview with the Social Service Director (SSD) QQ on 3/8/2017 at 3:55 p.m. revealed that she had been in-serviced on the updated Elopement Policy and Procedures and the Reporting Process. She was questioned on her knowledge of the process and was aware of the updated policy and procedure and who to contact should someone elope or attempt to elope from the facility. Interviews with Resident Care Specialists (RCS), also known as Certified Nursing Assistant (CNAs) on 3/8/2017 revealed that RCS RR at 3:58 p.m., RCS TT at 4:05 p.m., RCS VV at 4:15 p.m., RCS XX at 4:25 p.m., RCS YY at 4:30 p.m. and RCS ZZ at 5:00 p.m. had attended in-services regarding the updated Elopement Policy and Procedures, Reporting Process and ensure that resident's with Wanderguards had them in place. They were aware of what events to report to the DON and/or Administrator and what to do if they did not respond to their call, what a Code Yellow is and what to do if the Wanderguard system is alarming. They were aware of how to report to the Corporate Compliance line and the SSA complaint number as well. An interview with Housekeeper OO on 3/8/2017 at 3:50 p.m. revealed that he had attended in-service on 2/22/2017 regarding the updated Elopement Policy and Procedure and Reporting Process. He was aware of what events to report to the DON and/or Administrator and what to do if they did not respond to their call, what a Code Yellow is and what to do if the Wanderguard system is alarming. He was also aware of how to report to the Corporate Compliance line and the SSA complaint number as well. An interview, on 3/8/2017 with Licensed Practical Nurses (LPNs) revealed that LPN NN at 3:40 p.m., LPN SS at 4:00 p.m., LPN UU at 4:10 p.m., LPN WW at 4:20 p.m. and LPN DD, Unit Manager at 5:30 p.m. had all attended in-services regarding the updated Elopement Policy and Procedure and Report Process. They were aware that Wanderguards are to be checked for placement every shift and documented. They knew what events to report to the Administrator and/or DON and who to contact should the incident no be addressed or if they did not received a response. They were aware of the Corporate Compliance line number and how to contact the SSA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115145**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **03/08/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDERSON MILL HEALTH AND REHABILITATION CENTER	**2130 ANDERSON MILL RD AUSTELL, GA 30106**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) Interviews on 3/8/2017 with Dietary Training Manager BBB at 6:40 p.m., Dietary Manager CCC at 6:47 p.m. and Dietary Aide DDD at 6:49 p.m. revealed that they had attended in-services on the updated Elopement Policy and Procedure and were aware of what to do if they heard the Wanderguard system alarming, who to report this incident to and who to report if there was no response. They were aware of the Corporate Compliance line and how to report to the SSA. 15. Review of the Staff Survey Questions form revealed that the facility department managers were questioning one employee per day utilizing the Staff Survey Questions form. Review of the Staff Survey Questions revealed that on 2/24/2017, 25 staff had completed questionnaires, on 2/25/2017, two staff had completed questionnaires, on 2/26/2017 one staff member had completed the questionnaire, on 2/27/2017, 14 staff had completed questionnaires, on 2/24/2017, 14 staff had completed questionnaires, on 3/1/2017, two staff had completed questionnaires, on 3/2/2017, two staff had completed questionnaires, on 3/3/2017, six staff had completed questionnaires, on 3/4/2017, one staff had completed questionnaires, on 35/2017, one staff had completed questionnaires, on 3/5/2017, one staff had completed questionnaires, on 3/6/2017, 43 staff had completed questionnaires, on 3/7/2017, 55 staff had completed questionnaires, on 3/8/2017, 30 staff had completed questionnaires and were knowledgeable of the Policy and Procedure on Elopement and what/who to contact if the DON or Administrator did not respond to a notification of events that require notification. 16. Review of the sign in sheets for the Adhoc Quality Assurance/Performance Improvement (QAPI) meeting dated 3/6/2017 revealed the following members in attendance: The Medical Director via conference call, the interim Administrator, Accounts Receivable Coordinator, the interim DON, interim Maintenance Director, Director of Regulatory Compliance, and other management staff. The Immediate Jeopardy was discussed, as well as, the related complaints. The findings of the monitoring/audit tools will be reviewed at the monthly QAPI meetings. An interview with the Medical Director on 3/8/2017 at 1:34 p.m. revealed that he participated in the 3/6/2017 Adhoc QAPI meeting where the issue of elopement was discussed and what measures had been put into place to prevent a reoccurrence.